Women doctors in South Africa

A survey of their experience and opinions

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Summary

The proportion of women entering medical school has increased at some faculties but remains at around 20% at others. A postal survey of 2 626 women on the Medical Register of the South African Medical and Dental Council was conducted to investigate aspects related to their work. Fifty-five per cent responded, with a possible bias towards older doctors and graduates from Afrikaans-language faculties.

Although a significant majority (86,5%) are in practice, about one-third (33,4%) are employed part-time and nearly one-third (29,4%) reported that they had experienced an interruption of their careers for periods of more than 5 years. Major factors relating to this wastage of medical resources identified by this study were the women's dual responsibility at home and at work, the one-time joint taxation system and discrimination in the workplace, in particular with regard to housing loans.

Few women find their way into specialist practice (18,5%), teaching or research, although 68,2% indicated that they would have liked to specialise. Home responsibilities (48,2%) and the structure of the curriculum (31,5%) were the commonly reported difficulties experienced with further study. In addition, the lack of part-time training and the geographical location of such facilities also played a role.

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There is a great need for developing medical manpower to meet the demands of patient care, education and research in South Africa.[1] The demand stems from, and is aggravated by, a multitude of factors. The demography reveals a diversity of peoples, developed and developing. A greatly varying disease profile is based on poverty and particular social structures on the one hand and destructive lifestyles of a Western industrialised country on the other. The complex profile is reflected by high death rates for infections and parasitic diseases, trauma, circulatory diseases and some cancers.[2] To this background of disease must be added the rapid urbanisation of many rural people, making unprecedented demands on medical services and introducing new risks for developing ill-health through adopting an urban lifestyle. The potential AIDS epidemic will also aggravate the task of supplying health services.

Furthermore, with the government's policy of curbing state expenditure teaching institutions are going into decline and there is a serious erosion of medical faculties with a loss of human resources to the private sector and overseas.[3] For these reasons new resources must be sought and developed.

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Whether women contribute to their full potential in medicine has been a matter of debate and investigation in several countries. Much of the discussion relates to gender, discrimination, equal opportunities and the functions and attributes considered by society to be womanly.[4-7]

In view of the growing number of admissions of women to some South African medical schools (Fig. 1) it is important to study the role played by women doctors in this country. This study aimed to investigate the factors thought to influence the contribution made by women at all levels of medical endeavour. We also sought to identify those factors that could be considered inhibiting to the fulfilment of their professional lives. The findings could be of value to medical schools when considering their admission criteria and curricular structures, as well as to the South African Medical and Dental Council, the body which determines minimum standards of education in medicine and is responsible for professional registration of doctors of all categories.

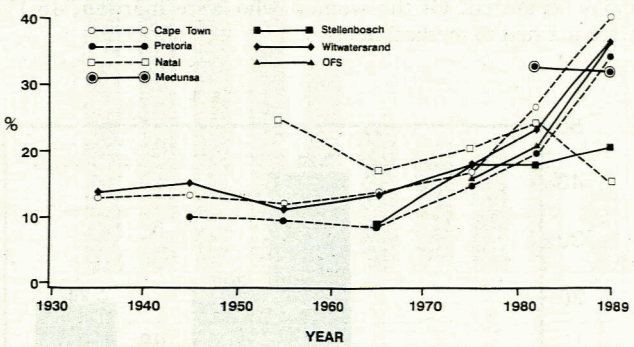

Fig. 1. Percentage of women medical graduates from South African universities from 1930 to 1989.

Subjects and methods

An interactive computer program was designed to identify female doctors on the basis of their first names from a total of 18 937 names on the 1983 Medical Register of the South African Medical and Dental Council.[8] In 1986 a questionnaire was mailed to the 3 370 doctors thus identified who had addresses in South Africa. A section of the questionnaire was designed to obtain demographic and circumstantial characteristics. The rest of the questions attempted to elicit information on factors relating to possible career impediments and disadvantages, such as discrimination practices, domestic functions and having children that could obstruct entry to medical studies and specialisation, or cause disruption of courses and job dissatisfaction.

Frequencies and percentages were used to summarise the information obtained from the survey.

The response

From the returns of the postal survey it was established that 744 of the medical practitioners originally identified were

either men or were not currently living in South Africa. Of the remaining 2 626, 55% responded to the postal survey. A comparison between the responders and non-responders was undertaken, based on information available from the Register, including the universities they had studied at, the provinces in which they resided, the year in which they had qualified and whether they were registered as specialists or not. Graduates from the Universities of Pretoria and Stellenbosch had the highest response rates, as did those women who had qualified between 1941 and 1950. The response rate was higher among specialists than general practitioners.

Further attempts to improve the representatives of the survey by sampling from the non-responders at a much later stage yielded a response rate of 60% the sample of non-responders (46 women responded). Although these women could be considered similar to the original group of responders (on the basis on χ^2 tests), it was decided to leave them out of further analyses as their overall contribution would be minimal and the time delay could introduce a bias.

Results

Background information

The age distribution of responders is shown in Fig. 2. Nearly half were aged 30 - 40 years. The majority replied that English was their home language (56,2%), followed by Afrikaans (34,0%). Seventy per cent were currently married, while 16,6% were unmarried, 7,4% divorced, 5,5% widowed and 0,5% separated. Of the women who were married, 46,1% were married to medical doctors.

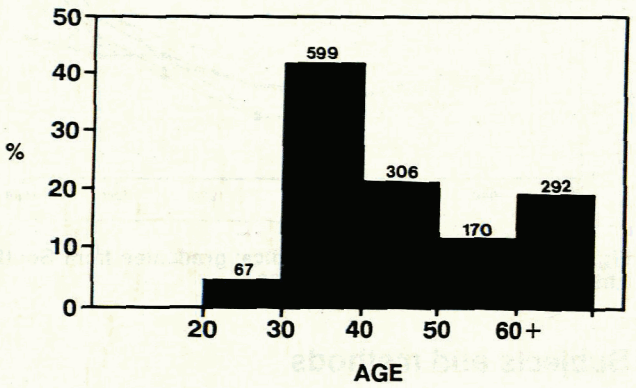

Fig. 2. Age distribution of 1 434 responders.

Only 14,1% of the women were registered as specialists. Many of the respondents also had non-medical qualifications, which were mostly in natural sciences (6,5%), human sciences (3,7%) and the arts (2,1%).

Child care

The number of dependent children the responders had is shown in Table I. In order to look after their children 51,5% had had to adapt their full-time or part-time professional practice for a period longer than 5 years. The distribution of the length of this period is shown in Table II. More than half of those who had had to adapt (51,5%) had needed to do so for a period longer than 5 years; 15% had not been able to work at all for longer than 5 years, while 29,8% had adapted by working part-time for less than 5 years.

TABLE I. DISTRIBUTION OF THE NUMBER OF DEPENDENT CHILDREN

No. of children	%*
None	44,3
1	15,0
2	23,0
3	12,2
≥ 4	5,5

* Of 1 444 respondents.

TABLE II. PERIOD OF ADAPTATION OF PROFESSIONAL PRACTICE TO LOOK AFTER CHILDREN*

Period (yrs)	%†
1	13,8
1 - 5	30,3
5 - 10	22,9
10 - 15	14,8
≥ 15	13,8
Did not specify	4,3

*Working part-time or not at all.
†Of the 825 respondents who had had to adapt this professional practice.

Experience acquired

When asked in which areas experience had been acquired after qualifying, 3 673 experiences could be placed in seven categories. The type of experience acquired is shown in Fig. 3. The majority of the experience (57,6%) was in general medicine (public and private), only 18,9% being in private practice. A much smaller proportion (10,8%) was in specialties (public and private), with no more than 4,1% in private practice. Only 3,2% was in research and 4,6% in lecturing. The experience was acquired on a part-time basis in 31,7% of cases.

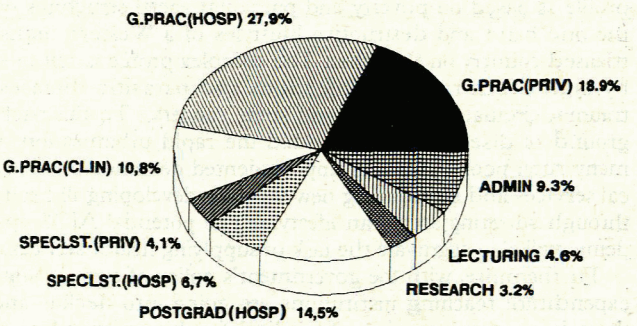

Fig. 3. Categories of experience acquired by women doctors (3 673 experiences).

Working in the medical field

When asked whether they were at present working in the medical field, 86,5% of the respondents indicated that they were; of this group 66,2% were working full-time and 33,4% part-time, while 0,4% did not indicate whether their work was full-time or part-time. Of the 215 reasons given for not working in the medical field, the majority (53,0%) were that the woman was permanently retired. However, when women over the age of 65 years were excluded, retirement accounted for only 23% of reasons. The most common given by women

under the age of 65 years was caring for children (51,3%). All the reasons given for not working in the medical field are set out in Table III.

TABLE III. REASONS FOR NOT WORKING IN THE MEDICAL FIELD

Reasons	All ages (%)*	Under 65 yrs (%)†
Caring for children	**27,9**	**51,3**
Permanently retired	**53,0**	**23,0**
Other reasons	**9,8**	**12,4**
No available posts	**4,7**	**6,2**
Working in a non-medical field for renumeration	**3,3**	**4,4**
Studying full-time	**1,4**	**2,7**

*Of 215 respondents.
†Of 113 respondents.

Stopped practising for domestic reasons

When asked whether they had ever had to stop practising their profession due to domestic reasons, 813 women (56,3%) indicated that they had. On the 981 occasions when these women had had to stop practising, 57,5% were working full-time and 42,3% were working part-time. Of those who had had to stop practising, only 1,5% felt that they were no longer competent in their profession. The majority (65,6%) had little difficulty in resuming their work, but a considerable proportion (34,4%) had not found it easy.

Desire to specialise or do full-time research

Of the 1 240 non-specialists, 68,2% indicated that they would have liked to specialise or study further. The most commonly selected specialty was paediatrics, followed by anesthesiology. Preferences for the various specialties are shown in Table IV.

TABLE IV. PROPORTIONS OF NON-SPECIALISTS WHO WOULD HAVE LIKED TO SPECIALISE OR STUDY IN SPECIFIC FIELDS

Subjects	%*
Paediatrics	**16,3**
Anaesthesiology	**8,6**
Obstetrics and gynaecology	**7,4**
M. General practice	**6,6**
Medicine	**6,2**
Pathology (all specialties)	**5,6**
Community health	**5,2**
Dermatology	**5,0**
Psychiatry	**5,0**
Surgery (all specialties)	**5,0**
Diploma (occupational or community health)	**3,4**
Radiology (diagnostic)	**3,0**
Further research	**2,4**
Postgraduate degree	**2,2**
Ophthalmology	**1,8**
Radiology (therapeutic)	**1,3**
Otorhinolaryngology	**0,5**
Neurology	**2,6**

*Of 1 240 non-specialists.

When asked whether they would like to do full-time research, 10,5% of the respondents indicated that they would.

Difficulties or discrimination experienced by women doctors

Of the respondents 80,8% replied that they had experienced problems or difficulties in their careers because they were female (Fig. 4). More than 50% of the respondents had experienced difficulties with home responsibilities and more than 50% with joint taxation. In an open-ended question, 9,4% indicated that they had had difficulties other than those specified in the questionnaire, e.g. lack of support from a husband.

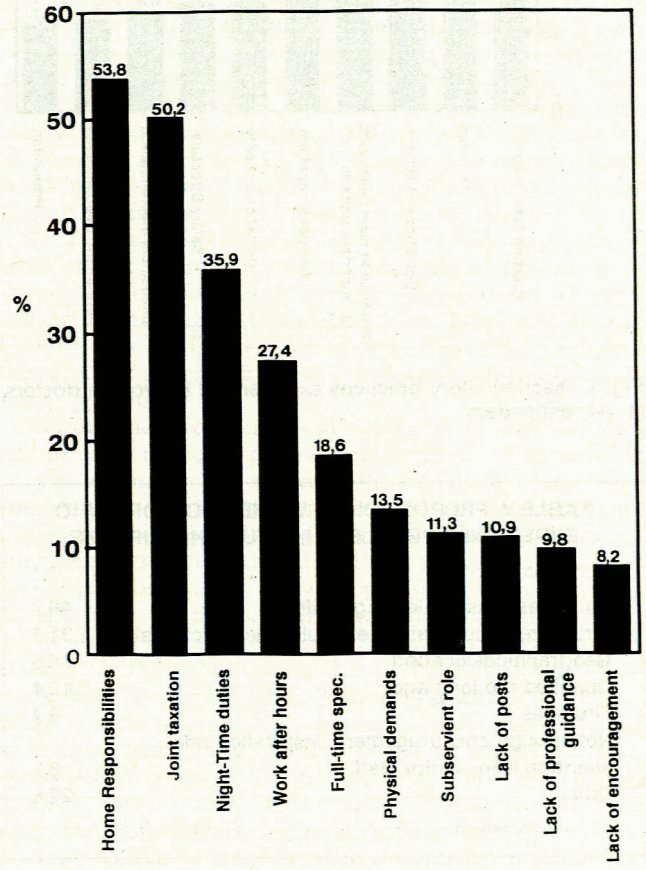

Fig. 4. Difficulties experienced by women doctors (1 444 responders).

Of the respondents 47,9% replied that they had experienced discrimination as a woman doctor (Fig. 5). Nearly 30% had experienced discrimination concerning a housing loan subsidy and 20% had experienced attitudinal discrimination. In an open-ended question, 5,6% responded that they had experienced discrimination other than those specified in the questionnaire, e.g. that senior staff preferred to act as mentor to male colleagues.

Problems in studying further

Of the respondents 59,4% indicated that they had experienced problems in studying further. The types of problems experienced are shown in Table V. It can be seen that the most common was home responsibilities (48,2%).

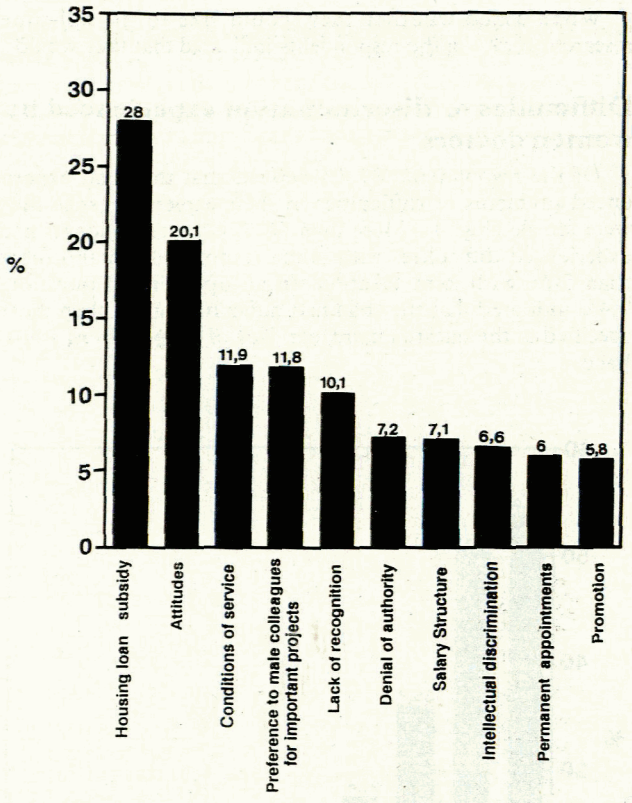

Fig. 5. Discriminatory practices experienced by women doctors (1 444 responders).

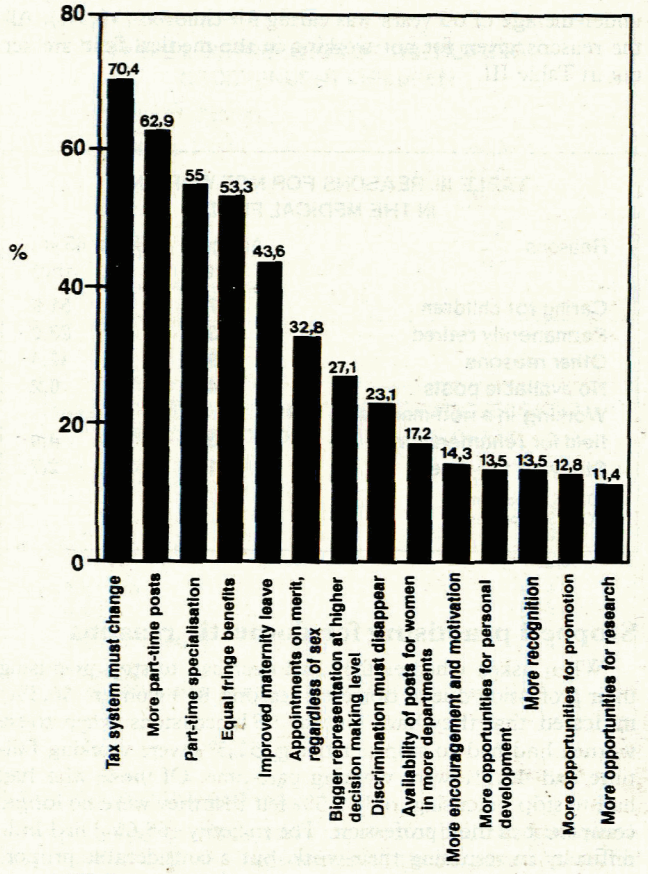

Fig. 6. Changes perceived by women doctors to be necessary for a better career potential (1 444 responders).

TABLE V. PROPORTION OF WOMEN DOCTORS WHO EXPERIENCE PROBLEMS IN STUDYING FURTHER

Problems	%*
Home responsibilities, e.g. children	**48,2**
Structure of curriculum, e.g. full-time specialisation	**31,5**
Geographical location	**15,5**
Qualified too long ago	**12,4**
Finances	**8,9**
Not enough encouragement, inspiration and attention from senior staff	**6,7**
Other	**22,6**

*Of 1 444 respondents.

Changes perceived necessary

The responses to the study suggest that several actions to improve career potential for woman doctors could be considered (Fig. 6).

The joint taxation system was most often identified as an obstacle (70,4%). Other important factors relate to appropriate service conditions allowing more part-time employment (62,9%) and training opportunities (55%). The identification and removal of discriminatory practices, andacceptance of the abilities of woman doctors to take more responsibility and to participate in decision-making, would also be of value.

Characteristics related to suitability for a medical career

The characteristics most commonly identified as pertaining to women and making them particularly suitable for a medical career (Fig. 7) were sensitivity (83,4%), empathy and sym-

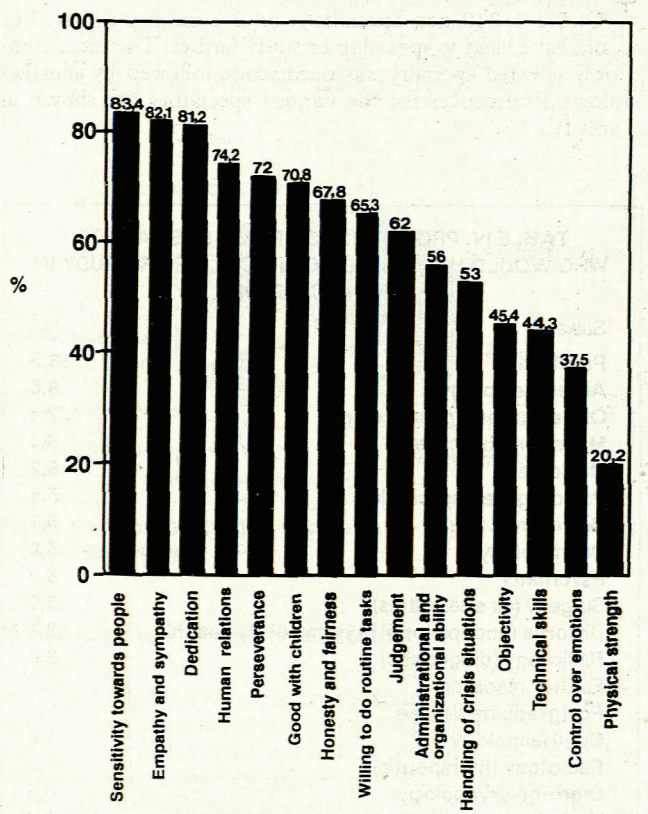

Fig. 7. Opinions regarding the characteristics that make a woman doctor particularly suitable for a career in medicine (1 444 responders).

pathy (82,1%) and dedication (81,2%). A high percentage furthermore, identified good human relations, perseverance and being good with children (more than 70%).

Lack of physical strength was identified by 36,6% of the respondents as making women unsuited to medicine, while 20,2% identified it as making them suitable. Nearly a quarter of the respondents (23,7%) considered the way a woman would handle a crisis as an unsuitable characteristic, while 53% considered it to be a suitable characteristic. Less than 20% of the responders identified any other characteristic as making women unsuited to medicine.

Opinions about training women doctors

The majority of the women surveyed indicated that they would encourage other women to train as a doctor (79,8%) and that they would make the same occupational choice were they to start again (81,2%). However, only 48,1% of the women doctors were of the opinion that more women should be trained in medicine (Table VI).

Discussion

Reluctance to respond is not unique to surveys undertaken on women doctors;[9-11] our response rate of 55% is relatively high. However, the survey possibly reflects greater motivation to participate on the part of older physicians and graduates from the Afrikaans-medium faculties.

In a recent report[12] it was stated that women were underrepresented as doctors in South Africa, only 17% of their sample of non-specialists and only 6% of specialists being women. As a result of the rapid increase of female graduates from some medical faculties the number of women in medical practice is already increasing significantly.

Nevertheless, only about 20% of graduates from the Natal and Stellenbosch faculties of medicine were women, compared with about 35% for the other faculties. The largest group of responders (599) was indeed in the age group 30 - 40 years, an indication of the larger numbers of women graduating from medical school in more recent times. This is also the experience in other countries.[8,13]

Our study confirms that a significant majority of women on the register (86,5%) are practising medicine, two-thirds of them full-time. This proportion is very similar to the 84% found in a survey conducted in 1974 by the South African Society for Medical Women.[14] Zwarenstein *et al.* [12] found that twice as many women doctors as men doctors are not employed in medicine and that almost three times as many are employed in a part-time capacity. Of the women doctors surveyed in this study, 29,4% had had to interrupt their work, by working part-time or not at all, for periods of longer than 5 years. One can conclude that a significant wastage of a work force occurs and that public funds spent on a long and difficult course are not fully utilised.

This study indicates that a major reason for this loss of manpower is the woman's responsibilities to her family. The majority of the respondents (70%) were married and many (57,1%) had had to interrupt their work to take care of their children. This factor has been recognised by others as a major one concerning women's relatively lesser role in medicine, and it has been discussed often, almost invariably in association with considerations of equal opportunity and discrimination.[4, 5, 7-11, 13, 15]

A very high proportion of our respondents (80%) had experienced difficulties in their careers because they were women. Although half had experienced problems related to home responsibilities, a unique South African factor appears to have been equally important, namely the joint taxation system whereby the incomes of husband and wife were combined for taxation purposes. This has been a strong disincentive for women to earn, encouraging them not to practise fully or even not to do so at all. Recent changes in the taxation of married couples are unlikely to remedy this problem, because the relief was aimed at the lower income levels. Several other obstacles were also experienced. Most related to the difficult demands of a medical career on time, such as night-time duties or after-hours work. As men doctors were not surveyed, we do not know whether these difficulties are unique to women.

Discrimination, because they were women, was encountered by half the respondents. In this context, too, we see a particular South African discriminatory process whereby women are not eligible for housing loans unless they are the breadwinners in a family. Lack of support from husbands and preference of senior staff for male colleagues were also identified as problems.

South Africa is desperately in need of more academic staff and of more medically qualified researchers.[1,3] The ranks of women are an obvious source to draw from. It is only after specialisation, however, that such careers can become meaningful and productive. For both men and women this is a long, strenuous and economically demanding route. Zwarenstein *et al.*[12] have indicated that a low proportion of women doctors are specialists. Of the experience gained by our respondents, 10,7% was in specialist practice, 3,2% in research and 4,6% in teaching — this despite the fact that 68,2% indicated that they would have liked to specialise. Problems preventing them from doing so were predominantly related to home responsibilities and the curriculum structures, which do not permit part-time specialisation in any of the medical disciplines. Geographical location, where women find themselves in remote areas or far from training facilities, also plays a significant role.

It seems that women find medicine rewarding, since the vast majority of our respondents indicated that they would make the same career choice if they were able to start again and would encourage other women to follow the same course. The fact that only 48,1% thought that more women should be trained in medicine could indicate that many do not perceive the under-representation of women in medicine. Most respondents believed that women have many personal attributes in human relations that would enhance their ability to practise

TABLE VI. RESPONSES TO QUESTIONS CONCERNING THE TRAINING OF WOMEN DOCTORS*

	Yes (%)	Unsure (%)	No (%)
1. Would you encourage a woman to follow the M.B. Ch.B. course?	**79,8**	**12,6**	**7,6**
2. Would you make the same occupational choice, were you able to start again?	**81,2**	**11,4**	**7,3**
3. Are you of the opinion that more women should be trained in medicine?	**48,1**	**32,3**	**19,5**

*1 444 respondents.

medicine. However, a sizeable proportion (36,6%) thought that lack of physical strength made women unsuited to a medical career.

The results of this survey suggest that several actions that would improve career potential for female doctors could be considered. Discriminatory practices should, of course, disappear. Joint taxation was identified as a major obstacle. Further consideration should be given to service conditions, job opportunities and part-time training.

Part-time employment and training were identified by Saxe and Van Niekerk[16] as possible solutions to enable women to re-enter medicine. Sixty-three per cent of the women in our survey indicated a need for part-time posts to be instituted. Saxe and Van Niekerk[16] made the observation that part-time sessions were available but were sometimes not rewarding owing to their routine and undirected nature. They indicated the need for part-time employment providing opportunities for career advancement and job satisfaction. Despite attempts by the South African Society for Medical Women to promote part-time training through meetings with heads of training departments, the SAMDC still requires training to be on a full-time basis in order to register for a specialty. Fifty-five per cent of the women in our survey indicated that it would be necessary to change this in order to improve the potential of a medical career.

In order to reduce the wastage of medical resources and to allow women doctors to realise this potential more fully, these matters should be given further attention.

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